Instructions for the Revised Home Health Advance Beneficiary Notice (HHABN)

I. Overview

Historically, home health agencies (HHAs) have issued advance beneficiary notices (HHABNs) related to the absence or cessation of Medicare coverage only when a beneficiary had liability protection under §1879 of the Social Security Act (the Act). Now, consistent with the Lutwin decision, HHAs must also issue HHABNs in a broader set of circumstances in conjunction with their responsibilities under Conditions of Participation (COPs) for HHAs. These instructions explain how to complete the new form and how and when the form should be delivered.

II. Scope and Time Frame of HHABN Instructions

A. Transition to the New HHABN

HHAs must begin using this new HHABN exclusively no later than September 1, 2006. Additional instructions for use of the new HHABN will be incorporated into the CMS manual system in August 2006.

B. Notices

The new notices and instructions have been approved by the Office of Management and Budget (OMB) for a 3 year period ending 8/31/2009. All Medicare liability notices are posted at www.cms.hhs.gov/BNI/, along with links to instructions.

Note the term "beneficiary" includes either the beneficiary or the beneficiary's authorized representative, as applicable. Therefore, these instructions apply whether the HHA gives the HHABN to a beneficiary or an authorized representative. For more information on authorized representatives, see Chapter 30, §40.3.5

C. Applicability

As before, financial liability protection notices like the HHABN continue to be mandatory for individuals enrolled in Original or Fee-For-Service (FFS) Medicare, consistent with section 1879 of the Act. Historically, CMS advised that HHAs were required to issue HHABNs only in those specific situations where "limitation on liability" (LOL) protection is afforded under section1879 for items(s) and/or service(s) ordered by physicians that the HHA believed Medicare would not cover. The HHABN is still required in these situations for the anticipated denial reasons listed in following chart:

Application of LOL for the HH Benefit

Citation from the Act	Brief Description of Situation	Explanation
§1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for such care
§1862(a)(9)	Custodial care is the only care delivered	Medicare does not usually pay for such care, except for some

		hospice services
§1879(g)(1)(A)	Beneficiary is not homebound	Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit
§1879(g)(1)(B)	Beneficiary does not need intermittent skilled nursing care	Medicare requires this need in order to cover services under the home health benefit

(Note that for care provided by HHAs that is outside the Medicare home health benefit, the only LOL requirement that will apply is section 1862(a)(1)(A) of the Act, involving care that is not reasonable and necessary.)

In addition to its continued use as a liability notice required under section 1879 of the Act, the HHABN and the associated notification procedures have also been adapted to meet the requirements of the 2nd Circuit's decision in Lutwin v. Thompson. Accordingly, consistent with the Medicare Conditions of Participation, home health agencies must also provide a standard, written notice whenever they reduce or terminate a beneficiary's home health services. According to the court's decision, this requirement applies whether the reason for the reduction was a "….Medicare coverage determination, lack of physician's certification, a HHA's unwillingness to provide services for business reasons unrelated to coverage, or sheer caprice."

D. Triggering Events

Thus, HHAs now are required to issue HHABNs whenever any of the following "triggering events" takes place, even if beneficiary liability is not at issue:

HHABN Triggering Events

EVENT	DESCRIPTION
A. Initiation	When a HHA expects that Medicare will not cover any planned items and/or services from the start of a course of treatment given over a spell of illness, **OR** before the delivery of one-time items or services that Medicare is not expected to cover.
B. Reduction	When a HHA reduces or stops some items and/or services during a spell of illness, while continuing others, including when one home health discipline ends but others continue.
C. Termination *	When a HHA ends delivery of all Medicare-covered care, but expects to continue delivering other care.

(* Note: Only an "expedited determination notice" (CMS-10123) is required if no further care is being delivered.)

Please keep in mind that triggering reductions and terminations under the home health benefit may apply for purposes of either covered or noncovered care. Outside the home health benefit, triggering reductions and terminations continue to apply only to covered care that:

- Is a Medicare benefit, i.e., durable medical equipment;
- Conforms to LOL requirements, i.e., is assumed to be medically
- unreasonable/unnecessary; and
- Is believed to involve beneficiary liability.

Finally, in keeping with standing Medicare liability notice practices, another HHABN must be furnished whenever ongoing continuous noncovered care exceeds a year in duration.

III. How to Use the HHABN

A. HHABN Preparation

The following are the general instructions HHAs must follow in preparing any HHABN:

1. Number of Copies: A minimum of two copies, including the original, must be made so the beneficiary and HHA each have one.

2. Reproduction: HHAs may reproduce the HHABN by using self-carbonizing paper, photocopying the HHABN, or other appropriate methods. All reproductions must conform to applicable instructions.

3. Length and Page Size: The HHABN must NOT exceed one page in length. The HHABN is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information HHAs insert in the notice, such as the HHA's name, list of item(s) and/or service(s) that will no longer be provided, cost information.

4. Contrast of Paper and Print: A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print (e.g., white on black), or block-shade (highlight) notice text.

5. Modification: The HHABN may not be modified, except as specifically allowed by applicable instructions.

6. Font: The HHABN must meet the following requirements in order to facilitate beneficiary understanding:

a. **Font Type:** To the greatest extent practicable, the fonts as they appear in the HHABN downloaded from the RHHI/CMS website should be used. Any changes in the font type should be based solely on software and/or hardware limitations of the HHA. Examples of easily readable alternative fonts include Arial, Arial Narrow, Times Roman, and

Courier.

b. **Font Effect/Style:** Any changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the HHABN more difficult to read.

c. **Font Size:** The font size generally should be 12 point. Titles should be 18 point, but insertions in blanks of the HHABN can be as small as 10 point if needed.

d. **Insertions in Blanks:** Information inserted by HHAs in the blank spaces on the HHABN may be typed or legibly hand-written.

7. Customization: HHAs are permitted to do some customization of HHABNs, such as pre-printing agency-specific information to promote efficiency and to ensure clarity for beneficiaries. Guidelines for customization are:

a. HHAs may have multiple versions of the HHABN specialized to common treatment scenarios, using all the required language and formatting of the HHABN, but with pre-printed language in its blanks.

b. HHAs may print different versions of HHABNs on different color paper to easily differentiate the versions, but in all cases a high-contrast combination of light paper and a dark font color should be used.

c. HHAs may also differentiate versions of their HHABNs by adding letters ornumbers in the header area.

d. Underlining in the blank spaces is not required.

e. Information in blanks that is constant can be pre-printed, such as the HHA name, or the Medicare telephone numbers (1-800-MEDICARE or 1-800-633-4227) and TTY (1-877-486-2048).

f. Pre-printed information in the blanks should be in 12-point font size wherever possible, with a minimum of 10-point in smaller blanks, such as that for cost information.

g. If pre-printed multiple options are used describing the items or services and reasons for noncoverage, the beneficiary should only see information applicable to his/her case clearly indicated in each blank or checked off in a checkbox.

h. Checkboxes for disciplines, if used to describe items and services, must still allow for explanation of what is changing; for example: " Physical Therapy: <u>Reduced to 2 times per week</u>." Just checking off a discipline without an explanation could render the notice invalid.

i. HHA staff should have HHABNs without pre-printed information on hand to allow for unusual cases that do not conform to pre-printed language for items or services or reasons for noncoverage.

HHAs must exercise caution before adding any customizations beyond these guidelines, since changing HHABNs too much could result in invalid notice and provider liability for noncovered charges. CMS liability notice policy generally bases validity determination on two factors: effective delivery and beneficiary comprehension as described in the Medicare Claims Processing Manual, Chapter 30. CMS does not validate adaptations of the HHABN made by individual HHAs. Validity judgments are generally made by RHHIs, usually when reviewing HHABN-related claims.

B. HHABN Completion and Delivery

The new HHABN continues to be a one-page notice, composed of four sections:

- Header Section
- Body Section
- Option Boxes
- Signature/Date Section.

However, CMS releases this HHABN in a file that contains four pages. The first page is instructional and never distributed to beneficiaries-- it is marked "SAMPLE" in the bottom right corner. It has instructions for filling in the blanks and boxes in the notice. To differentiate the instructions from the actual notice text, the instructions are printed in a different font in the appropriate blanks.

The next three pages are "ready to use" HHABNs. The second page is a HHABN with Option Box 1 text is placed into the boxed area of the notice-- it is marked "OPTION BOX 1" in the bottom right corner. The third page is an HHABN with Option Box 2 text in the boxed area-- it is marked "OPTION BOX 2" in the bottom right corner. The last page is also a blank HHABN, this time with the new Option Box 3 text in the boxed area-- it is marked "OPTION BOX 3" in the bottom right corner. See section B.2.b below regarding which option box to use.

1. The Header Section

HHAs are permitted to customize the header section of the HHABN. The header section is above the title of the notice, "Home Health Advance Beneficiary Notice," which appears in larger point font size at the top of the page.

After downloading the notice from the RHHI/CMS website, HHAs add identifying information, including HHA name, logo, and billing address. At minimum, information allowing the beneficiary to contact the HHA must appear, including the provider name and address (telephone number is given elsewhere on the notice).

2. The Body Section and Option Boxes

a. Instructions for the Body Section

The body section of the HHABN is below the header and above the option boxes. The HHA starts by inserting standard information into the following two blanks in this section:

Step 1: The HHA inserts its name in the blank space provided in the sentence beginning "We,_____, your home health agency,. . .". Since the entry in the "Step 1" blank is the same no matter what option box is used, the name can be pre-printed in the notice.

Step 2: In the next blank beginning "are letting you know that we_____", the HHA inserts the appropriate phrase, depending on which option box is used (see below).

Step 3: The HHA must describe on the blank lines immediately after "with the following items and/or services:_____..." the item(s) and/or service(s) that are the reason for issuing the HHABN.

Regarding Step 3:

- The HHA should describe either the items or services that Medicare will no longer cover but may still be provided by the HHA (Option Box 1 only), the applicable reduction in items or services, or the termination of all Medicare-covered care.
- General descriptions of multi-faceted services or supplies are permitted. For example, "wound care supplies" would be sufficient description of a group of items used to provide this care, an itemized list is not required. However, when a reduction occurs, HHAs should provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies weekly (now to be provided monthly)" would be appropriate to describe a decrease in frequency of this nature.

Step 4: After the word "Because:_____..." the HHA must describe why the item(s) and/or service(s) listed are expected not to be covered by Medicare, or will no longer be provided by the HHA.

Regarding Step 4:

- The reasons provided must be in plain language that allows the beneficiary to understand the reason for the notice and enables the beneficiary make an informed choice about accepting financial liability when applicable. The information must convey more than simply that care is "not reasonable or necessary." The level of detail given should at minimum be similar to that found in a Medicare Summary Notice (MSN) message. For example, a Step 4 entry could be "you are no longer homebound" or, even more consistent with the related MSN message, "you can now leave your home unaided." Both phrases are examples of concise yet complete explanations of a common yet specific

reason why according to Medicare policy the home health benefit may not be covered for an improving individual. If needed, additional explanation would be provided verbally when delivering the notice-- see III. C. below.

- If multiple items or services are listed by the HHA in Step 3, and there are different reasons for including these multiple things on the HHABN, the HHA is responsible for providing sufficient information in Step 4 to allow the beneficiary to understand the reasons associated with each item or service.

Step 5: In the paragraph beginning, "If you have questions . . .", the HHA must enter its own telephone number, or provide a TTY number for speech or hearing impaired beneficiaries when appropriate.

b. Use of the Option Boxes

The following chart summarizes the circumstances in which each option box should be used.

Triggering Event	Option Box 1	Option Box 2	Option Box 3
INITIATIONS			
Initiations of Entirely Noncovered Treatment, Any Medicare Benefit, when §1879 LOL Applies	**Yes**	No	No
One-time Items/Services, Beneficiary Liable, Any Medicare Benefit, §1879 LOL Applies	**Yes**	No	No
One-time Items/Services, §1879 LOL Doesn't Apply **and/or** Not a Medicare Benefit	Voluntary	No	No
REDUCTIONS			
Reduction for HHA Reasons, No Beneficiary Liability, HH Benefit	No	**Yes**	No
Reduction by Physician Order, HH Benefit	No	No	**Yes**
Other Reductions, HH Benefit	**Yes**	No	No
Other Reductions, Other Medicare Benefits, §1879 LOL Applies	**Yes**	No	No
Other Reductions	Voluntary	No	No
TERMINATIONS			
Termination for HHA Reasons, No Beneficiary Liability, HH Benefit	No	**Yes**	No
Termination for Coverage Reasons (Including Physician Orders), Any Medicare Benefit Given in a Treatment Plan/Over a Duration of Time	**Yes***	No	No
Other Terminations (not HH Benefit)	Not Required	No	No

(* Note: Expedited Determination Notice MUST be given, and HHABN is also needed only when noncovered care continues after coverage ends.)

See below for additional instructions.

i. Instructions for Option Box 1

Option Box 1 is used when:

- Beneficiary faces potential liability/will be receiving noncovered care/will be charged,
- Beneficiary wants a claim filed for potentially noncovered care the HHA provides,

- The care at issue is other than the Medicare home health benefit (though Option Box 1 is also used for the home health benefit when one of the other conditions listed here applies),
- Beneficiary will be charged for an assessment although not admitted to care, OR
- Any circumstance that may arise for which neither Option Box 2 or 3 is appropriate.

If Option Box 1 is being used, HHAs should insert the most appropriate of the following phrases in the Step 2 blank in the body of the HHABN:

- "will not provide you (if choosing Box 1 below)"
- "will no longer provide you (if choosing Box 1 below)"
- "believe Medicare will not provide you"
- "believe Medicare will no longer provide you"

The text insertion for Option Box 1 is in quotation marks below:

Option Box 1 Text

"The estimated cost of the items and/or services listed above is $_____
_____.
If you have other insurance, please see #3 below.

You have three options available to you. You must choose only one of these options by checking the box next to the option and then signing below:

□ 1. I don't want the items and/or services listed above. I understand that I won't be billed and that I have no appeal rights since I will not receive those items and/or services.

□ 2. I want the items and/or services listed above, and I agree to pay myself since I don't want a claim submitted to Medicare or any other insurance I have. I understand that I have no appeal rights since a claim won't be submitted to Medicare.

□ 3. I want the items and/or services listed above, and I agree to pay for the items and/or services myself if Medicare or my other insurance doesn't pay. Send the claim to:
(**Please check one or both boxes**):
□ Medicare
□ My other insurance. _____

Please note: If you select option 3 and a claim is submitted to Medicare, you will get a Medicare Summary Notice (MSN) showing Medicare's official payment decision. If the MSN indicates that Medicare won't pay all or part of your claim, you may appeal Medicare's decision by following the appeal procedures in the MSN. If you don't receive an MSN for your claim, you can call Medicare at: (___) _____. TTY: (___) _____. You may have to pay the full cost at the time you get the items and/or services. If Medicare or your other insurance decides to pay for all or part of the items and/or services that you have already paid for, you should receive a refund for the appropriate amount.

By signing below, I understand that I received this notice because this Home Health Agency believes Medicare will not pay for the items/services listed, and so I chose the option checked above."

Step 1: The HHA must provide an estimate of the total cost of the items and/or services listed in the body section in the first blank in this option box. Since one or multiple items and services could be at issue, the HHA must enter a total cost that reflects each item or service as clearly as possible, including information on the period of time involved when appropriate (i.e., not a one-time service). For example:

- "$400 for 4 weekly nursing visits in 1/06."

- "$210 for 3 physical therapy visits 1/3-17/06, $50 for medical equipment." (Specific pieces of durable medical equipment [DME] should be identified as space allows.)

NOTE:

- The cost estimate is meant to give the beneficiary an idea of what costs would be if he/she paid out of pocket, not what the beneficiary may actually have to pay given other coverage. The fact that the idea other insurance might pay appears next in the HHABN after the cost estimate, so that HHAs are prompted to explain to beneficiaries cases where other insurance will cover costs.

- The estimated cost reported on the HHABN may be $0 if, for example a HHA chooses not to charge a beneficiary, or if bundled payments with no beneficiary liability are involved.

- Since it may be not possible for HHAs to project all possible costs for future periods into one blank, a proxy like average daily cost can be given. For example, if an average day involves a skilled nursing visit, an average visit charge or private fee charge master amount for this service could be used to give a daily cost, noting when possible the duration over which continuing care could be expected. Consistent with previously policy, the intent is to provide a reasonable estimate sufficient to assist the beneficiary in making a decision to accept or decline potential financial responsibility.

- The HHA must annotate the amount the beneficiary may have to pay if he/she later chooses to receive only certain items or services of those listed on the HHABN instead of everything originally listed.

- If abbreviations are used, the HHA should explain their meaning to the beneficiary verbally. We have expanded the space available for cost information to help minimize the need for abbreviations.

Step 2: Check Boxes and the Related Insurance Blank. The two sets of check boxes--the first concerning the beneficiary's desire to get the items or services at issue and numbered 1-3, and the second under Check Box 3 indicating whether Medicare and/or another insurer should be

billed--are NEVER completed in advance. See C.1.below on delivery of the HHABN for further discussion of completion of these check boxes. However, the HHA may fill in the blank for other insurance in advance when it is familiar with the coverage of a beneficiary, such as an established patient.

Step 3: In the space provided in the "Please note:" section of Option Box 1, the HHA must provide the Medicare phone number in the first blank and, in the second blank, and the TTY telephone number or directions for using Medicare's other telecommunication system when appropriate for individuals with impaired speech or hearing. The phone number is: 1-800-MEDICARE (or 1-800-633-4227), the TTY number is: 1-877-486-2048. These numbers may be pre-printed when the HHA prepares the HHABN.

ii. Instructions for Option Box 2

Option Box 2 is used when the HHA decides to stop providing some or all care for its own financial and/or other reasons, regardless of Medicare policy or coverage, such as: the availability of staffing, closure of the HHA or safety concerns in a beneficiary home. This language should be used when:

- There is no beneficiary liability,
- There is no further delivery of the care described in the body of the HHA (it is a reduction or termination, not a change from covered to noncovered for coverage of ongoing care),
- There is no related claim (i.e., nothing is being provided to bill).

Option Box 2 could seem appropriate in similar cases when benefits other than home health are involved. However, notification is not required in these cases, and additionally the wording of this option box references home care. An HHA may issue notices with Option Box 2 language voluntarily to provide notice that it will not charge or admit a beneficiary after an assessment is done.

Steps for Completion. If Option Box 2 is used, HHAs should insert the following phrase in the Step 2 blank in the body of the HHABN:

"will no longer provide you"

However, there is no information to complete in Option Box 2 itself, as shown below:

Option Box 2

> **"By signing below**, I understand that I received this notice because this Home Health Agency decided to stop providing the items and/or services listed above. The Agency's decision doesn't change my Medicare coverage or other health insurance coverage. I can't appeal to Medicare since this Home Health Agency won't provide me with any more items and/or services; however, I can try to get the items and/or services from another Home Health Agency.

Please note that there are many different ways to find another Home Health Agency, including by contacting your doctor who originally ordered home care. You may then ask the new Home Health Agency to bill Medicare or your other insurance for items and/or services you receive from them."

iii. Instructions for Option Box 3

Option Box 3 is used when the HHA stops providing certain items and/or services due to lack of a physician order, but other care continues. Thus, Option Box 3 is appropriate when:

- There is no beneficiary liability,
- There is no further delivery of the care described in the body of the HHA (it is a reduction, not a change in coverage from covered to noncovered for ongoing care),
- There is no related claim (i.e., nothing is being provided to bill).

Option Box 3 could seem appropriate in cases when benefits other than home health are involved and affected by similar changes to required physician orders. However, notification is not required in these cases, and additionally the wording of this option box references home health.

Steps for Completion. If Option Box 3 is used, HHAs should insert the following phrase in the Step 2 blank in the body of the HHABN:

"will no longer provide you"

However, there is no information to complete in Option Box 3 itself, as shown below:

Option Box 3

"By signing below, I understand that I received this notice because my doctor has changed my orders and so my home health plan of care is changing. This home health agency has explained to me that they cannot provide home care without a doctor's order."

3. The Signature and Date Section

Once the beneficiary has reviewed and understands the information contained in the HHABN (see III. C. below), the HHA must request that the beneficiary complete all four blanks in the boxed Signature and Date Section at the bottom of the HHABN. The four blanks are:

- **Patient's Name:** The beneficiary's full name should be inserted in the blank.
- **Medicare # (HICN):** The beneficiary's Medicare health insurance claim number should be inserted in the blank.
- **Signature:** The beneficiary must personally sign the HHABN.
- **Date:** The beneficiary must personally enter the date that the HHABN was

completed.

NOTE: The HHA may complete the first two blanks to assist the beneficiary.

If the beneficiary refuses to sign the HHABN, the HHA must write that the beneficiary refused to sign on the HHABN itself, and provide a copy of the annotated HHABN to the beneficiary.

C. HHABN Delivery

When delivering HHABNs to beneficiaries, HHAs are required to explain the entire notice and its content, and answer all beneficiary questions orally to the best of their ability. HHAs must make every effort to ensure beneficiaries understand the entire HHABN prior to signing it. Note that while preferable, in-person delivery is not required consistent with general ABN requirements, see Chapter 30, §40.3.4.1.

1. Option Box 1

While reviewing this option box, the HHA should instruct the beneficiary to select only one of the 3 numbered check boxes. The HHA must advise the beneficiary that if the third check box is chosen, the beneficiary then must indicate in the blank provided whether a claim should be submitted to Medicare, to the beneficiary's other listed insurer(s), or to both.

2. Option Box 2

There is no information in this option box for the beneficiary to complete. However, the HHA must review the text in the box, including explaining orally to the beneficiary that he/she may be able to obtain the same or similar care from another HHA, since coverage through Medicare is not affected. HHAs are encouraged to do as much as possible to offer ideas to beneficiaries for contacting other HHAs, especially since HHAs still need to try to assure patients reach the goals of care plans even when discharging, and must inform ordering physicians of reductions/ terminations consistent with the COPs for HHAs.

3. Option Box 3

There is no information in this option box for the beneficiary to complete. However, the HHA must review the text in the box, including telling the beneficiary that the HHA will no longer provide certain care because the physician order has changed. When requested, the HHA may subsequently facilitate contact and understanding between the physician and beneficiary, and when applicable, aid in understanding the coverage limits of the Medicare home health benefit and of home care in general. The beneficiary may also seek to contact the physician directly.

D. Retention of the HHABN

The HHA keeps the original version of the completed HHABN, whether annotated or signed, in the beneficiary’s record. The beneficiary HHA receives a copy of the completed HHABN.